2016 Medical Benefits Highlights – I.B.E.W. Local 77

The purpose of this document is to help you make decisions; it is not a contract. Details are provided in your medical plan booklet at http://www.seattle.gov/personnel/resources/benefits_documents.asp.

Group Health Cooperative (GHC)	City of Seattle Traditional Plan		City of Seattle Preventive Plan	
	Preferred Provider	**Non-Preferred Provider**	**Aetna In-Network**	**Out-of-Network**
Deductible (per calendar year)				
No deductible	$100 per person $300 per family	$150 per person $450 per family	Does not apply	$250 per person $750 per family
Annual Out of Pocket Maximum (OOP Max) includes copays and coinsurance after any applicable deductible. Excludes prescription drug copays				
$750 per person $1,500 per family	$200 per person. $600 per family	$1,200 per person. $3,600 per family	$500 per person $1,000 per family	$3,000 per person $6,000 per family
Total Annual Out of Pocket Maximum: includes medical copays, coinsurance, and the deductible. Excludes prescription drug copays				
$750 per person $1,500 per family	$300 per person $900 per family	$1,350 per person $4,050 per family	$500 per person $1,000 per family	$3,250 per person $6,750 per family
Hospital Copay				
None	None	None	None	None
Hospital Pre-admission Authorization				
Except for maternity or emergency admissions, must be authorized by GHC	Except for maternity or emergency admissions, your physician must contact Aetna prior to your admission	Member responsible for obtaining precertification of out-of-network care	Except for maternity or emergency admissions, your physician must contact Aetna prior to your admission	Member responsible for obtaining precertification of out-of-network care
Choice of Providers				
All care and services must be approved and/or provided by GHC or GHC designated providers. Members may self-refer to most GHC specialists.	Any Aetna contracted provider member. No primary care physician selection required. No referrals required.	Any licensed, qualified provider of your choice. Expenses paid based on reasonable* charges. You pay the difference between R&C and billed charges.	Any Aetna contracted provider member. No primary care physician selection required. No referrals required.	Any licensed, qualified provider of your choice. Expenses paid based on reasonable* charges. You pay the difference between R&C and billed charges.

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COVERED EXPENSES				
Acupuncture				
Paid at 100% after $10 copay. Self-referred up to 8 visits per condition per calendar year. Additional visits when approved by plan.	Paid at 80% Maximum of 12 visits per calendar year.	Paid at 60%	Paid at 100% after $10 copay All acupuncture services are subject to ongoing review and approval by Aetna for medical necessity.	Paid at 70%
Alcohol/Drug Abuse Treatment				
Inpatient: Paid at 100% Outpatient: Paid at 100% after $10 copay	Paid at 80% for inpatient and outpatient	Paid at 80% for inpatient and outpatient	Inpatient: Paid at 100% Outpatient: Paid at 100% after $10 copay	Inpatient: Paid at 70% Outpatient: Paid at 70%
Contraceptives				
For contraceptive drugs and devices, see Prescription Drug benefit	Contraceptive devices and other products covered as medical benefits. (See Prescription Drugs.)	Contraceptive devices and other products covered as medical benefits. (See Prescription Drugs.)	Contraceptive devices and other products covered as medical benefits. (See Prescription Drugs.)	Contraceptive devices and other products covered as medical benefits. (See Prescription Drugs.)
Durable Medical Equipment				
Paid at 80%	Paid at 80% Breast pump covered at 100% through DME provider	Paid at 80%	Paid at 100% Breast pump covered at 100% through DME provider	Paid at 70%
Emergency Medical Care				
➢ **Urgent Care Clinic**				
Paid at 100% after $10 copay	Paid at 80%	Paid at 80%	Paid at 100% after $35 copay	Paid at 70%
➢ **Emergency Room (copays waived if admitted)**				
GHC facility: Paid at 100% after $75 copay Non-GHC facility: Paid at 100% after $75 deductible	Paid at 80%.	Paid the same as in-network except if it's non-emergency, then it's 60%	Paid at 100% after $50 copay	Paid the same as in-network except if it's non-emergency, then it's 70% after $50 copay
➢ **Ambulance**				
Paid at 80% GHC-initiated non-emergency transfers are paid at 100%	Paid at 80% when medically necessary. Non-emergency transport must be approved in advance.		Paid at 100% when medically necessary. Non-emergency transport must be approved in advance.	
Hospital Inpatient				

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Paid at 100%	Paid at 80%	Paid at 60%	Paid at 100%	Paid at 70%
Hospital Outpatient				
Paid at 100% after $10 copay	Paid at 80%	Paid at 60%	Paid at 100%	Paid at 70%
Hospice				
Paid at 100%	Paid at 90%		Paid at 100%	Not covered
Maternity Care (delivery & related hospital)				
Paid at 100%	Paid at 80%	Paid at 60%	Paid at 100%	Paid at 70%
Maternity Care (prenatal and postpartum)				
Paid at 100% after $10 copay. Routine care not subject to outpatient services copay	Paid at 80%	Paid at 60%	Paid at 100% after $10 copay	Paid at 70%
Mental Health Care (inpatient)				
Paid at 100%	Paid at 80%	Paid at 60%	Paid at 100% after $10 copay	Paid at 70%
Mental Health Care (outpatient)				
Paid at 100% after $10 copay	Paid at 80%.	Paid at 60%	Paid at 100% after $10 copay	Paid at 70%
Physician Office Visit				
Paid at 100% after $10 copay	Paid at 80%	Paid at 60%	Paid at 100% after $10 copay	Paid at 70%

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Prescription Drugs (retail)				
For a 30-day supply: **Generic**: $10 copay. **Brand**: $10 copay Contraceptive drugs and devices are covered in full. Selected preventive over-the-counter drugs covered at 100% in certain situations. Your pharmacy copays will apply to the annual out of pocket maximums.	For a 34-day supply or 100 unit supply (whichever is greater): **Generic and brand prescriptions**: $15 copay Generic oral contraceptives are covered at 100%. Contraceptive devices and other prescription contraceptive products are covered under the medical plan benefits. Selected preventive over-the-counter drugs covered at 100% in certain situations. Non-formulary drugs not covered.	Not covered	For a 31-day supply: **Generic**: $10 copay **Preferred brand**: $10 copay **Non-preferred drugs**: $40 copay Generic oral contraceptives are covered at 100%. Contraceptive devices and other prescription contraceptive products are covered under the medical benefit. Select preventive over-the-counter drugs covered at 100% in certain situations.	Not covered
Prescription Drugs (mail order)				
For a 90-day supply: Generic: $30 copay Brand: $30 copay Contraceptive drugs and devices are covered in full. No copay on all smoking cessation drugs through mail order. Your pharmacy copays will apply to the annual out of pocket maximums.	For a 90-day supply: Generic and brand prescriptions: $30 copay Non-formulary drugs are not covered. Generic oral contraceptives covered at 100%	Not covered	For a 90-day supply: **Generic**: $20 copay **Preferred brand**: $40 copay **Non-preferred drugs**: $80 copay Generic oral contraceptives are covered at 100%	Not covered
Prescription Drugs Annual Out of Pocket Maximum				
Included in annual out-of-pocket maximum	$1,200 per person $3,600 per family	Not covered	$1,200 per person $3,600 per family	Not Covered

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Preventive Care				
Paid at 100% for adult physical and well child exams and most immunizations and preventive services	Paid at 100% Covers adult physical and well child exams, immunizations, digital rectal exams/PSA, colorectal cancer screening	Paid at 60% for mammograms, deductible waived. No other preventive services covered.	Paid at 100% Covers adult physical and well child exams, immunizations, digital rectal exams/PSA, colorectal cancer screening	Paid at 70% for well woman care and mammograms. No other preventive services covered.
Rehabilitation Services (inpatient)				
Paid at 100% Maximum of 60 days per calendar year for occupational, speech, and physical therapy.	Paid at 80%	Paid at 60%	Paid at 100%	Paid at 70% 120 days per calendar year for skilled nursing and rehab services in-network and out-of-network combined.
Rehabilitation Services (outpatient)				
Paid at 100% after $10 copay Maximum of 60 visits per calendar year for occupational, speech, and physical therapy.	Paid at 80%	Paid at 80% Coinsurance does not apply to out-of-pocket maximum. Maximum calendar year benefit of 30 visits for all services combined (physical/massage, speech, occupational and cardiac/pulmonary therapy).	Paid at 100% after $10 copay	Paid at 70% Benefit includes physical/massage, speech, occupational and cardiac/pulmonary therapy. Coinsurance does apply to the annual out-of-pocket maximum. Maximum of 20 visits per calendar year for each of the above listed benefits for in-network and out-of-network combined.
Skilled Nursing Facility				
Paid at 100%; 60 day maximum per calendar year	Paid at 80%	Paid at 80% Maximum of 90 days per calendar year	Paid at 100%	Paid at 70% Maximum of 120 days per calendar year for in-network and out-of-network combined
Smoking Cessation				
Paid at 100% for individual/group sessions through Quit For Life. Nicotine replacement therapy included in Prescription Drugs benefit. No copay on all smoking cessation prescription drugs through mail-order.	Lifetime maximum of one 90-day supply of smoking cessation aids or drugs. See Prescription Drugs, retail.	Not covered	Only covers counseling	Only covers counseling

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Spinal Manipulations				
Paid at 100% after $10 copay. Self-referral to GHC-designated providers. Must meet GHC protocol. Maximum of 10 visits per calendar year.	Paid at 80% Maximum of 10 visits per year for in-network and out-of-network combined	Paid at 80%	Paid at 100% after $10 copay Maximum of 20 visits per calendar year for in-network and out-of-network combined	Paid at 70%
Sterilization Procedures				
Inpatient: Paid at 100% Outpatient: Paid at 100% after $10 copay Women's sterilization procedures covered in full	Paid at 80%	Paid at 60%	Inpatient: Paid at 100% Outpatient: Paid at 100% after $10 copay.	Paid at 70%
Tooth Injury (due to accident)				
Not covered	Paid at 80% Maximum $600 per occurrence	Paid at 80%	Inpatient: Paid at 100% Outpatient: Paid at 100% after $10 copay.	Paid at 70%
Vision Exam/Hardware				
Exam: Paid at 100% after $10 copay. One exam every 12 months. Hardware: Not included	Covered under VSP		Covered under VSP	
X-ray and Lab Tests (Outpatient)				
Paid at 100%	Paid at 80%	Paid at 60%	Paid at 100%	Paid at 70%

* Applies to Aetna -- Recognized charges are the lower of the provider's usual charge for performing a service, and the charge Aetna determines to be the recognized charge percentage in the geographic area where the service is provided.

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